October 2014 - Monthly Provider Support Call Summary

Please share with your case managers and administrative staff or other employees.

Each month the WDH-Behavioral Health Division holds a monthly provider support call to let providers know what is going on and give additional clarification on items that have been released. **The next call is Monday, November 24th at 2pm.**

CALL TOPICS & SUMMARY

Objectives and Schedules Reminder

The Division would like to remind all providers that, for the services that require it, you are required to develop and track objectives on how you will be assisting participants in working toward completing an overall goal during services. Each provider should work with the team, including the case manager, participant, and guardian to develop the objectives. You are also required to track the progress of each objective to determine if the participant is getting closer to achieving the goal or whether the objectives must be changed to better suit the participant.

After tracking the objectives for the month, the provider then submits the schedules, including the tracking information to the case manager by the 10th business day of the following month. Once the information is received, case managers are required to review the information you submit and assess overall progress of goal completion and to determine if any given objective is appropriate or if it needs to be changed or modified to meet the needs of the participant.

If you require additional information and training on developing objectives and how to track the progress, please refer to the Objectives and Schedules training Module found on the Division Website: https://ddtrainings.health.wyo.gov/index.html

CM semi-annual plan reviews – Question & Response

We had a question about 6 month review meetings from a CM - I think because CMs held additional meetings for the transition to the new waiver, some within the last few months, and are wondering if they now still need to do the 6 month review. The CM asked "Are we supposed to continue with the participant's 6 month review regardless of when the new plan is effective?

Therapies – Question & Response

Maintenance therapy can be paid from the waiver, and is not covered on the State plan. A doctor's order is still needed. A question received is if the doctor orders the therapies, does the team have to utilize the budget first for the therapies, since it is doctor ordered?

The answer is up to the team. Doctors have asked for skilled nursing or therapies before, and if the team feels it is not needed or the stuff that needs done can be by regular staff, then the team does not have to put the services on the plan.

HCBS Transition Plan Overview *(talking points for public comment during the call)*

Summary of Purpose

On March 17, 2014, the Centers for Medicaid and Medicare Services (CMS) promulgated new federal regulations for Home and Community Based (HCB) Waiver Service Settings requirements. The federal regulations are 42 CFR 441.301(c)(4)-(5). CMS posted additional guidance to help states assess compliance and remediate areas that are not fully incompliance. More information on the rules can be found on the CMS website at www.medicaid.gov/hcbs. **Each waiver has a separate, detailed transition plan posted online.**

A Youtube video of the forum presentation is also on the Division's website with more information.

- CMS's Intent with the new rules is to ensure that services are truly provided in the community.
- HCBS stands for Home and Community Based services.
- Some HCBS settings have been criticized for being overly institutional in nature. Like mini-institutions in cities and towns across each state.
- The rule creates first-ever federal standards to ensure Medicaid HCBS is provided in settings that are non-institutional in nature
- Went into effect March 17, 2014. States have until March 16, 2019 to be fully in compliance or the settings that are not must be withdrawn from the waiver program and participants transitioned out of those waiver services.
- The new rules apply to all Medicaid programs that provide home and community based services. The new rules apply to most of our Wyoming waivers: Comprehensive Waiver, Supports Waiver, ABI waiver, Child DD waiver, Assisted Living Facility Waiver
- CMS expects an inventory of HCB settings to determine if they are in compliance, need modifications to be in compliance, are not going to meet HCB standards, or are not HCB in nature but will should be considered for
- No waiver amendments or renewals can be made or approved until our HCB Setting Transition Plan is approved by CMS.
- All states must develop a transition plan by March 16, 2015. Wyoming needs it sooner, so the Acquired Brain Injury waiver and Assisted Living Facility Waiver can be approved….and so amendments to the Supports and Comprehensive Waivers can be approved.

Benefits to the HCB Setting Requirements as stated by CMS:

- They establish an outcome oriented definition that focuses on the nature and quality of individuals' experiences (not specific size limitations on homes or anything)
- They maximize opportunities for individuals to have access to the benefits of community living and the opportunity to receive services in the most integrated setting

These are locations that are presumed by CMS to have institutional qualities and will not be considered an HCBS setting

- In building with facility providing inpatient institutional.
- On the grounds of, or adjacent to public institution.
- Any other setting that has the effect of isolating individuals receiving Medicaid HCBS from the broader community of individuals not receiving Medicaid HCBS (The last one I mentioned is where we have to focus our evaluation and changes in Wyoming.)

There are core standards that apply to all types of HCBS Settings:

- Integration
- Choice
- Independence and
- Rights

The Home and Community-Based setting requirements described by CMS:

- Setting is integrated in and supports access to the greater community
- Setting provides opportunities to seek employment and work in competitive integrated settings, engage in community life, and control personal resources
- Setting ensures the individual receives services in the community to the same degree of access as individuals not receiving Medicaid home and community-based services

Let's look at these standards closely.

The Provider operated setting must meet these requirements:

- Each individual has privacy in their sleeping or living unit and rooms must have lockable entrance doors, with the individual and appropriate staff having keys to doors as needed.
- A participant has the right to furnish or decorate the living unit within the scope of the lease or other residency agreement
    - So if a person must have a lease or agreement with a specific unit/dwelling if it is owned, rented, or occupied by a participant, and it has to be protected under legally enforceable agreement
    - Same responsibilities/protections from eviction as all tenants under landlord tenant law of state, county, city or other designated entity
    - If tenant laws do not apply, state ensures lease, residency agreement or other written agreement is in place providing protections to address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law

    (*So this requirement does not apply to adults living at home with family…unless the provider is the family member!)*
- A participant must have freedom and support to control his or her schedule and activities, and access to food at any time. Minimal options, such as the choice of a snack bar or crackers, will not meet the requirement.
- Individuals sharing units have a choice of roommates
- A participant has the right to have visitors of his or her choosing at any time. Visitation should be done in a way that respects the preferences of other participants living in the facility or setting. A lease or other residency agreement could limit the extent to which a visitor can stay due to the comfort of other people in the setting.
- Setting must be physically accessible to the individual receiving services – more than just ADA compliant in some cases. Everyone who uses a wheelchair for instance, may have different needs in the setting depending on the size and functionality of the wheelchair.

Can these standards be modified for any reason?

- Prior to modification, the provider first must attempt alternative strategies — "positive interventions and supports" and "less intrusive methods of meeting the need that [were] tried but did not work."
- Modification is allowed if it is supported by a specific assessed need and justified in the participant's plan of care.
- Importantly, modification is allowed only with the informed consent of the participant (or, as appropriate, the participant's guardian.)
- Also, the plan of care must include "regular collection and review of data to measure the ongoing effectiveness of the modification," and "time limits for periodic reviews to determine if the modification is still necessary or can be terminated."
- Consent can be withdrawn at any time.
- The restriction must be specific to the person's needs, not the needs of others in the setting and not general to a specific "condition". Hence, a diagnosis of "Diabetes" is not enough to restrict access to food.
- Also, the plan of care must include "regular collection and review of data to measure the ongoing effectiveness of the modification," and "time limits for periodic reviews to determine if the modification is still necessary or can be terminated."

The new rules also include a requirement for person centered planning and conflict free case management, which cannot be a part of the state's 5 year transition. They must be in place now, but they know some states are having to make adjustments.

Here is what we have done so far:

- ✓ Developed a citizen Transition Taskforce
- ✓ Conducted research on topics within the new standards, such as informed choice
- ✓ Brainstormed with taskforce members on state standards that will align with the new federal rules
- ✓ Conducted a provider setting survey
- ✓ Developed draft transition plan and state standards

Timeline

- Year 1 we are gathering provider setting inventory, conducting analysis, and getting the plans to CMS.
- Here is an overview of the timeline for years 2 through 4. (Please look at the detailed timelines and milestones posted to our website.)
- Providers must address the area of non-compliance for a setting *characteristic* issue by the end of year two (by March 16, 2016) with policy and process changes,
- with full implementation and evaluation of changes by the end of year three (by March 16, 2017).
- Any setting *location* issue must be addressed by the end of year four (by March 16, 2018) with evaluation in year five.

Next Steps

- We will evaluate the input we received on our draft transition plans and submit them to CMS.
- CMS will approve transition plans of up to five years. Length of transition period depends on different state circumstances. CMS expects states to transition to new settings requirements in as brief a period as possible.
- Providers will be issued a report of where they are not in compliance.
- Providers will develop a detailed action plan with milestones and timelines to make changes to services, setting characteristics, locations, or service delivery in order to come into full compliance.
- State must approve each provider transition plan.

Public comment on this plan will close on November 3, 2014. *(But we will always accept comments)*

- Comments can be sent via email to bhdmail@wyo.gov or to our office address.
- Or you may want to complete the stakeholder online survey at: https://www.surveymonkey.com/s/publicHCBSsurvey
- Visit BHD-DD Section website: http://health.wyo.gov/ddd. It will have the updated plan will be posted after comment period.

Support call notes are now posted to our website:
http://health.wyo.gov/ddd/ComprehensiveandSupportsWaiver.html

Your Questions:

SEFA – is a goal required?
The Division expects that the team specify the need for the follow along service and that the goal or purpose is clearly defined in the plan of care. There is not "participant support training" required with the service.

Questions on when the Case Management 15 minute unit would be in effect for each waiver.
The Division must get the transition plans approved for each waiver, then the Division can do a retrospective amendment on the unit change from a monthly unit to a 15 minute unit. The public comment period on the 15 minute unit went out, which is the requirement of CMS for any amendment. We hope for January and will let people know when we know that our transition plan was approved.

One provider requested a meeting with Division staff on the 15 minute unit, which the Division will arrange with that provider.

Next Call

Next call is Monday, November 24th at 2pm. Calls will be held on the last Monday of each month when there is no holiday interruption.

Thank you for reading and for making time to call in each month!